# Complete Summary

## GUIDELINE TITLE

Screening for prostate cancer: recommendations and rationale.

## BIBLIOGRAPHIC SOURCE(S)

Berg AO. Screening for prostate cancer: recommendations and rationale. Am J Nurs 2003 Mar;103(3):107-10. PubMed

Screening for prostate cancer: recommendations and rationale. Ann Intern Med 2002 Dec 3;137(11):915-6. [8 references] PubMed

## COMPLETE SUMMARY CONTENT



## SCOPE

### DISEASE/CONDITION(S)

Prostate cancer

### GUIDELINE CATEGORY

Screening

### CLINICAL SPECIALTY

Family Practice
Internal Medicine
Preventive Medicine

### INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel

Nurses
Physician Assistants
Physicians
Students

### GUIDELINE OBJECTIVE(S)

- To summarize the current U.S. Preventive Services Task Force (USPSTF) recommendations on screening for prostate cancer and the supporting scientific evidence
- To update the 1996 recommendations contained in the Guide to Clinical Preventive Services, second edition

### TARGET POPULATION

Adult males

### INTERVENTIONS AND PRACTICES CONSIDERED

1. Medical history including assessment of risk
2. Patient education regarding potential benefits/harms of screening
3. Screening for prostate cancer including:
    - Prostate specific antigen (PSA) test
    - Digital rectal examination (DRE)

### MAJOR OUTCOMES CONSIDERED

- Efficacy of screening in reducing mortality from prostate cancer
- Accuracy and reliability of screening tests in detecting prostate cancer
- Harms of screening
- Health outcomes of treatment
- Harms of treatment
- Costs/Cost-effectiveness of screening

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Research Triangle Institute/University of North Carolina Evidence-based Practice Center for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

### Literature Search Strategy and Synthesis

The analytic framework and key questions guided the literature searches. The Research Triangle Institute examined the critical literature described in the review by the USPSTF (published in 1996) and searched the reference lists of systematic reviews (including Cochrane Library reviews) published since 1993. The Research Triangle Institute then used their eligibility criteria to develop search terms and searched the MEDLINE database for relevant articles concerning humans in the English language published between January 1, 1994, and September 15, 2002. They especially looked for articles involving patients whose experience is clearly generalizable to a primary care US population.

The search strategy and results are given in Table 2 in the Systematic Evidence Review companion document. All searches started with the term â œprostate neoplasmâ and then proceeded by adding further terms as shown in the table.

### Inclusion/Exclusion Criteria for Admissible Evidence

The authors and Task Force liaisons developed inclusion and exclusion criteria for selecting the evidence relevant to answer the key questions (see Table 2 in the Systematic Evidence Review companion document). They first searched for evidence from randomized controlled trials (RCTs) for the efficacy of screening. As no well-conducted and well-analyzed RCT of screening were found, case-control and ecologic evidence regarding the overarching key question were then examined (Key Question 1).

For Key Question 2, concerning the operating characteristics of screening tests, the authors and Task Force liaisons examined well-conducted systematic reviews and individual studies that started with a primary care or unselected population without prostate cancer and that compared the findings of 1 or more screening tests with an adequate reference standard. For Key Questions 4 through 7, concerning the effectiveness of various therapies, they required evidence from RCTs with health outcomes. Key Questions 3 and 8, concerning the harms of screening or treatment, required either RCTs or well-controlled studies that included patient reports and at least 12 months of follow-up. Finally, a search was conducted for evidence of the costs and cost-effectiveness of screening, including models of potential benefits, that considered all appropriate costs and estimates of effectiveness supported by reasonable assumptions based on good evidence.

## NUMBER OF SOURCE DOCUMENTS

Key Question 1: Efficacy of Screening (Direct Evidence) - 3 articles

Key Question 1: Efficacy of Screening (Ecologic Studies) - 15 articles

Key Question 2: Yield of Screening Tests - 35 articles

Key Questions 3-6: Health Outcomes of Treatment - 2 articles

Key Question 7: Harms of Treatment - 23 articles

Key Question 8: Costs/Cost-Effectiveness of Screening - 2 articles

Key Question 9: Harms of Screening - 1 article

## METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

## RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The U.S. Preventive Services Task Force (USPSTF) grades the quality of the overall evidence on a 3-point scale (good, fair, or poor).

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies; generalizability to routine practice; or indirect nature of evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

Note: See the companion document titled "Current Methods of the U.S. Preventive Services Task Force: a Review of the Process" (Am J Prev Med 2001 Apr;20[3S]:21-35) for a more detailed description of the methods used to assess the quality and strength of the evidence for the three strata at which the evidence was reviewed.

## METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

## DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Research Triangle Institute-University of North Carolina Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

The Research Triangle Institute's first author reviewed abstracts of all articles found in the searches to determine which met eligibility criteria. Other authors reviewed all abstracts excluded by the first reviewer. The full text of all articles not excluded by both reviewers (see Table 2 in the Systematic Evidence Review companion document) was retrieved.

One reviewer then examined the full text of all retrieved articles against the inclusion/exclusion criteria and discussed all excluded articles with one of the other reviewers. Any article that either reviewer judged had met inclusion criteria (see Table 2 in the Systematic Evidence Review companion document) was included. Three of the authors then divided the articles and abstracted data from them, entering the relevant data into pre-designed evidence tables (see Appendix B in the Systematic Evidence Review companion document). The abstracting author also graded the articles using the criteria established by the Methods Work Group of the U.S. Preventive Services Task Force. The first author read all articles, checked the grading, and discussed the crucial ones with a second author. The authors also discussed key articles with the Task Force liaisons.

## METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

## DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to 'balance sheets') are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive services affects benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a 'close-call', then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

## RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of five classifications (A, B, C, D, or I), reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

A

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians provide [the service] to eligible patients. (The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.)

B

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves health outcomes and concludes that benefits outweigh harms.)

C

The U.S. Preventive Services Task Force (USPSTF) makes no recommendation for or against routine provision of [the service]. (The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms it too close to justify a general recommendation.)

D

The U.S. Preventive Services Task Force (USPSTF) recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

I

The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

## COST ANALYSIS

Given the uncertainties about the existence and magnitude of benefits, the cost-effectiveness of screening for prostate cancer has been difficult to calculate. A 1993 decision analysis, which made optimistic assumptions about benefit from screening and early treatment, found little or no benefit for men with well-differentiated tumors. For men with moderately or poorly differentiated cancer, screening and early treatment could offer as much as 3.5 years' improvement in quality-adjusted life expectancy, again using the most optimistic assumptions. Even with optimistic assumptions, men ages 75 years and older were not likely to benefit from screening and aggressive treatment. One major reason is that any benefits of screening are expected to accrue some years into the future, after many men of this age have died of some other condition. Two subsequent decision analyses have reached the same conclusions.

In 1995, Barry et al. published a cost-effectiveness analysis using favorable screening assumptions. The marginal cost-effectiveness of screening men age 65 years with prostate specific antigen (PSA) test and digital rectal examination (DRE), without adjustment for life quality and without discounting benefits, was between $12,500 and $15,000 per life-year saved. Changing only a few assumptions, however, quickly increased the marginal cost-effectiveness ratio to above $100,000 per life-year saved. This ratio would be even less favorable if a decrement in quality of life associated with the harms of treatment were considered. In 1997, these investigators updated their model with newer data and further assumptions favorable to screening; findings were similar.

From: Harris RP, Lohr KN. Screening for prostate cancer: an update of the evidence. Ann Intern Med. 2002 Dec 3;137(11):917-29 (see the "Companion Documents" field).

## METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center and the Agency for Healthcare Research and Quality send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the whole U.S. Preventive Services Task Force before final recommendations are confirmed.

Recommendations of Others. Recommendations for screening for prostate cancer from the following groups were discussed: the American Academy of Family Physicians (AAFP), the American Cancer Society, the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), the American Medical Association, the American Urologic Association and the Canadian Task Force on Preventive Health Care (CTFPHC).

# RECOMMENDATIONS

## MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

- The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routine screening for prostate cancer using prostate specific antigen (PSA) testing or digital rectal examination (DRE). I recommendation.

The USPSTF found good evidence that PSA screening can detect early-stage prostate cancer but mixed and inconclusive evidence that early detection improves health outcomes. Screening is associated with important harms, including frequent false-positive results and unnecessary anxiety, biopsies, and potential complications of treatment of some cancers that may never have affected a patient´s health. The USPSTF concludes that evidence is insufficient to determine whether benefits outweigh harms for a screened population.

Clinical Considerations

- Prostate specific antigen (PSA) testing and digital rectal examination (DRE) can effectively detect prostate cancer at early pathologic stages. There is insufficient evidence, however, that the currently available treatments (radical prostatectomy, radiation therapy, or hormonal therapy) reduce morbidity and mortality from early prostate cancer. Therefore, the benefit of screening for and treating early prostate cancer is unknown.
- Despite the absence of firm evidence of effectiveness, some clinicians may opt to perform screening for other reasons. Given the uncertainties and controversy surrounding prostate cancer screening, clinicians should not order the PSA test without first discussing with the patient the potential but uncertain benefits (reduction of morbidity and mortality from prostate cancer) and the possible harms (false-positive results, unnecessary biopsies, and possible complications of treatment) of prostate cancer screening. Men should be informed of the gaps in the evidence, and they should be assisted in considering their personal preferences and risk profile before deciding whether to be tested.
- If early detection improves health outcomes, the population most likely to benefit from screening will be men aged 50-70 years who are at average risk, and men over age 45 who are at increased risk (African American men and men with a family history of a first-degree relative with prostate cancer. Benefits may be smaller in Asian Americans, Hispanics, and other racial and ethnic groups that have a lower risk of prostate cancer. Older men and men with other significant medical problems who have a life expectancy of fewer than 10 years are unlikely to benefit from screening.
- PSA testing is more sensitive than DRE for the detection of prostate cancer. PSA screening with the conventional cut-point of 4.0 ng/ml detects a large majority of prostate cancers; however, a significant percentage of early prostate cancers (10-20%) will be missed by PSA testing alone. Using a lower threshold to define an abnormal PSA detects more cancers at the cost of more false positives and more biopsies.
- The yield of screening in terms of cancer detected declines rapidly with repeated annual testing. If screening were to reduce mortality, biennial PSA screening could yield as much benefit as annual screening.

Definitions:

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The USPSTF recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

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The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

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Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

## CLINICAL ALGORITHM(S)

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

#### Effectiveness of Early Detection

- The U.S. Preventive Services Task Force (USPSTF) found one randomized, controlled trial (RCT), and three case-control studies examining the effect of screening on prostate cancer mortality. The single RCT of prostate specific antigen (PSA) and digital rectal examination (DRE) screening, which reported a benefit from screening, was hampered by a low rate of acceptance of screening in the intervention group (24%), and by flaws in the published analysis; no difference in prostate cancer deaths was observed between the groups randomized to screening versus usual care using "intention to treat" analysis. Three case-control studies of screening DRE produced mixed results. A number of RCTs of PSA screening for prostate cancer are under way in both the U.S. and Europe, but they are not expected to report results for several years.
- Data are also limited to determine whether and how much treatment of screen-detected cancers improves outcomes. No properly controlled, prospective studies are available to determine whether prostatectomy or radiation, the most commonly used treatments for prostate cancer, reduce mortality or are more effective than "watchful waiting" for organ-confined prostate cancer. Several such trials are currently under way. In observational studies, outcomes are worst, and the potential impact of aggressive treatment greatest, for poorly differentiated cancers. In the absence of better data on which treatments are effective for which tumors, the USPSTF concluded that it could not determine whether the increased detection of prostate cancer from screening would reduce mortality and morbidity.
- The USPSTF also examined a variety of ecologic data, including studies of secular trends in prostate cancer mortality after introduction of PSA screening and comparisons of prostate cancer mortality rates in communities with and without screening. Prostate cancer mortality rates in the U.S. have declined since 1991. However, the available ecologic studies have not provided sufficient evidence that prostate cancer trends in the U.S. or other populations are attributable to screening; differences in prostate cancer treatment, underlying risk factors, and how deaths are classified can all introduce bias into ecological comparisons.

#### Subgroups Most Likely to Benefit:

If early detection improves health outcomes, the population most likely to benefit from screening will be men aged 50-70 years who are at average risk, and men over age 45 who are at increased risk (African American men and men with a

family history of a first-degree relative with prostate cancer). Benefits may be smaller in Asian Americans, Hispanics, and other racial and ethnic groups that have a lower risk of prostate cancer. Older men and men with other significant medical problems who have a life expectancy of fewer than 10 years are unlikely to benefit from screening.

### POTENTIAL HARMS

#### Potential Adverse Effects of Screening

- Evidence about the harms of screening per se is scant. The screening process is likely associated with some increase in anxiety, but the number of men affected and the magnitude of the increased anxiety are largely unknown. Some screening procedures cause transient discomfort. Fewer than 10% of men have ongoing interference with daily activities after biopsy, and fewer than 1% suffer more serious complications, including infections.
- Screening may result in harm if it leads to treatments that carry side effects without improving outcomes from prostate cancer, especially for cancers that have a lower chance of progressing. Erectile dysfunction, urinary incontinence, and bowel dysfunction are well-recognized and relatively common adverse effects of treatment with surgery, radiation or androgen ablation, but men differ in their responses to these symptoms.

#### Subgroups Most Likely to be Harmed:

- Current models show that men older than age 70 to 75 years are unlikely to benefit substantially from screening because of their shorter life-expectancy and higher false-positive rates.
- In asymptomatic older men, screening may detect cancers that appear clinically significant, based on size and tumor grade, but which would not have progressed to clinical symptoms in the patient's lifetime.

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

#### Cost and Cost-effectiveness

Given uncertainties about the effectiveness of screening and the balance of benefits and harms, the cost-effectiveness of screening for prostate cancer is impossible to determine. If one makes favorable assumptions about efficacy of screening, prostate specific antigen (PSA) screening may be cost-effective for men ages 50 to 69 years. If efficacy of early treatment is lower, harms could exceed benefits and PSA screening would not be cost-effective. Current models show that men older than age 70 to 75 years are unlikely to benefit substantially from screening because of their shorter life-expectancy and higher false-positive rates. Cost-effectiveness of different screening intervals or variations on PSA measurement is unknown.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Neither the resources nor the composition of the U.S. Preventive Services Task Force equip it to address these numerous implementation challenges, but a number of related efforts seek to increase the impact of future U.S. Preventive Services Task Force reports. The U.S. Preventive Services Task Force convened representatives from the various audiences for the Guide "Put Prevention Into Practice. A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach" - clinicians, consumers and policy makers from health plans, national organizations and Congressional staff - about how to modify the content and format of its products to address their needs. With funding from the Robert Wood Johnson Foundation, the U.S. Preventive Services Task Force and Community Guide effort have conducted an audience analysis to further explore implementation needs. The Put Prevention into Practice initiative at the Agency for Healthcare Research and Quality (AHRQ) has developed office tools such as patient booklets, posters, and handheld patient mini-records, and a new implementation guide for state health departments.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the third edition of the Guide to Clinical Preventive Services. Freed from having to serve as primary repository for all of

U.S. Preventive Services Task Force work, the next Guide may be much slimmer than the almost 1000 pages of the second edition.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals and test results are not always centralized.

### IMPLEMENTATION TOOLS

Foreign Language Translations
Patient Resources
Personal Digital Assistant (PDA) Downloads

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

### RELATED QUALITY TOOLS

- Pocket Guide to Good Health for Adults

- A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach

- Screening for Prostate Cancer. What's New from the USPSTF?

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Staying Healthy

### IOM DOMAIN

Effectiveness
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Berg AO. Screening for prostate cancer: recommendations and rationale. Am J Nurs 2003 Mar;103(3):107-10. PubMed

Screening for prostate cancer: recommendations and rationale. Ann Intern Med 2002 Dec 3;137(11):915-6. [8 references] PubMed

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

1996 (revised 2002 Nov)

### GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

### GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a Federally-appointed panel of independent experts. Conclusions of the USPSTF do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or DHHS agencies.

### SOURCE(S) OF FUNDING

United States Government

### GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

### COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Task Force Members: Alfred O. Berg, MD, MPH, (Chair); Janet D. Allan, PhD, RN, CS, FAAN (Vice Chair); Paul Frame, MD; Charles J. Homer, MD, MPH; Mark S. Johnson, MD, MPH; Jonathan D. Klein, MD, MPH; Tracy A. Lieu, MD, MPH; Cynthia D. Mulrow, MD, MSc; Tracy C. Orleans, PhD; Jeffrey F. Peipert, MD, MPH; Nola J. Pender, PhD, RN, FAAN; Albert L. Siu, MD, MSPH; Steven M. Teutsch, MD, MPH; Carolyn Westhoff, MD, MSc; Steven H. Woolf, MD, MPH

### FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task force has an explicit policy concerning conflict of interest. All members and evidence-based practice center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

## GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Screening for prostate cancer. In: Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996.

## GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Also available from Annals of Internal Medicine Online and the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

## AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Harris RP, Lohr KN. Screening for prostate cancer: an update of the evidence. Ann Intern Med. 2002 Dec 3;137(11):917-29. Electronic copies available from Annals of Internal Medicine Online.
- Harris RP, Lohr KN, Beck R, Fink K, Godley P, Bunton A. Screening for Prostate Cancer. Rockville (MD); Agency for Healthcare Research and Quality; 2002 (in process). (Systematic evidence review).

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the

process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):36-43.

Electronic copies: Available from U.S. Preventive Services Task Force (USPSTF) Web site.

Additional Implementation Tools:

- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2001. 189 p. (Pub. No. APPIP01-0001). Electronic copies available from the AHRQ Web site.

  Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

- The Preventive Services Selector, an application for Palm Pilots and other PDA's, is also available from the AHRQ Web site.
- Screening for prostate cancer. What's new from the USPSTF?. Rockville (MD): Agency for Healthcare Research and Quality; 2002 Dec. Electronic copies: Available from USPSTF Web site.

## PATIENT RESOURCES

The following is available:

- The Pocket Guide to Good Health for Adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Copies also available in Spanish from the USPSTF Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).



## NGC STATUS

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